

HOME AND COMMUNITY BASED OPTIONS AND PERSON-CENTERED EXCELLENCE (HOPE) WAIVER

OVERVIEW

The Home and Community Based Options and Person-Centered Excellence (HOPE) Waiver is operated by the Department of Human Services (DHS), Division of Long Term Services and Supports (LTSS). The purpose of the HOPE Waiver is to provide home and community-based services to South Dakotans age 65 and older as well as individuals 18 years of age and older who have a qualifying disability to allow them to remain at home or in the least restrictive environment available. The HOPE waiver utilizes Medicaid funding to provide home and community-based services to individuals that are risk for institutionalization. Oversight for providers of HOPE Waiver services is a collaboration between the DHS/LTSS and South Dakota Medicaid.

ELIGIBLE PROVIDERS AND LTSS ENROLLMENT

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Please refer to the [South Dakota Medicaid Provider Enrollment chart](#) for additional details on South Dakota Medicaid enrollment eligibility and supporting documentation requirement.

HOPE Waiver providers must meet both LTSS and South Dakota Medicaid Provider Enrollment requirements prior to LTSS initiating a Purchase of Services Agreement (contract) with the provider. HOPE Waiver providers must have a current contract with DHS/LTSS prior to receiving authorization to perform services to HOPE Waiver participants.

To enroll as a LTSS HOPE Waiver Provider, the provider must complete and submit the [LTSS HCBS Provider Enrollment Request](#) when their Medicaid application has been submitted. Once the Medicaid application has been submitted and LTSS HCBS Provider Enrollment request has been completed, an onsite review will be scheduled with LTSS staff.

There are different enrollment criteria depending on the [taxonomy code](#) the provider is enrolling in. LTSS provider enrollment requirements vary by each service outlined in the service-specific [LTSS Provider Provisions](#).

Once the DHS/LTSS and South Dakota Medicaid provider enrollment requirements have been met and an DHS/LTSS contract is in place, the Provider will receive an account in the LTSS' case management and billing system, Therap. LTSS will initiate a referral of the eligible individuals in the Therap to the Provider's account and the Provider will receive authorization for service to provide their enrolled service.

Once the Provider's Therap account set up is completed, the Provider will receive Therap system training from a Therap representative. The Therap case management system provides access to all

LTSS HCBS Providers to receive referrals for the Provider's contracted service(s). It is the Provider's responsibility to acknowledge and maintain Therap Service Auths and maintain Provider Therap account and account maintenance.

For more information on enrollment of HOPE Waiver and other LTSS services, refer to [LTSS HCBS Provider Enrollment Manual](#) and service-specific Provider Provisions located on the [LTSS Provider Resources page](#).

Below listed are the enrollment requirements for SD Medicaid HOPE Waiver services.

DHS LTSS Title XIX HOPE Waiver Services Enrollment Chart			
Services	LTSS Enrollment Review Required	LTSS Contract Required	HCBS Settings Final Rule Review Required
In-Home (Homemaker, Personal Care, Nursing, Adult Companion, Chore)	Yes	Yes	No
Respite/Residential Respite Care	Yes	Yes	No
Assisted Living	Yes	Yes	Yes
Structured Family Caregiving	Yes	Yes	No
Community Living Home	Yes	Yes	Yes
Adult Day	Yes	Yes	Yes
Community Transition Coordination	Yes	Yes	No
Community Transition Supports	Yes	Yes	No
Environmental Accessibility Adaptations Assessment	Yes	Yes	No
Environmental Accessibility Adaptations	Yes	Yes	No
Specialized Medical Equipment	No	No	No
Specialized Medical Supplies	No	No	No
Emergency Response Service	No	No	No
Nutritional Supplements	No	No	No
Meals	Yes	Yes	No

ELIGIBLE PARTICIPANTS

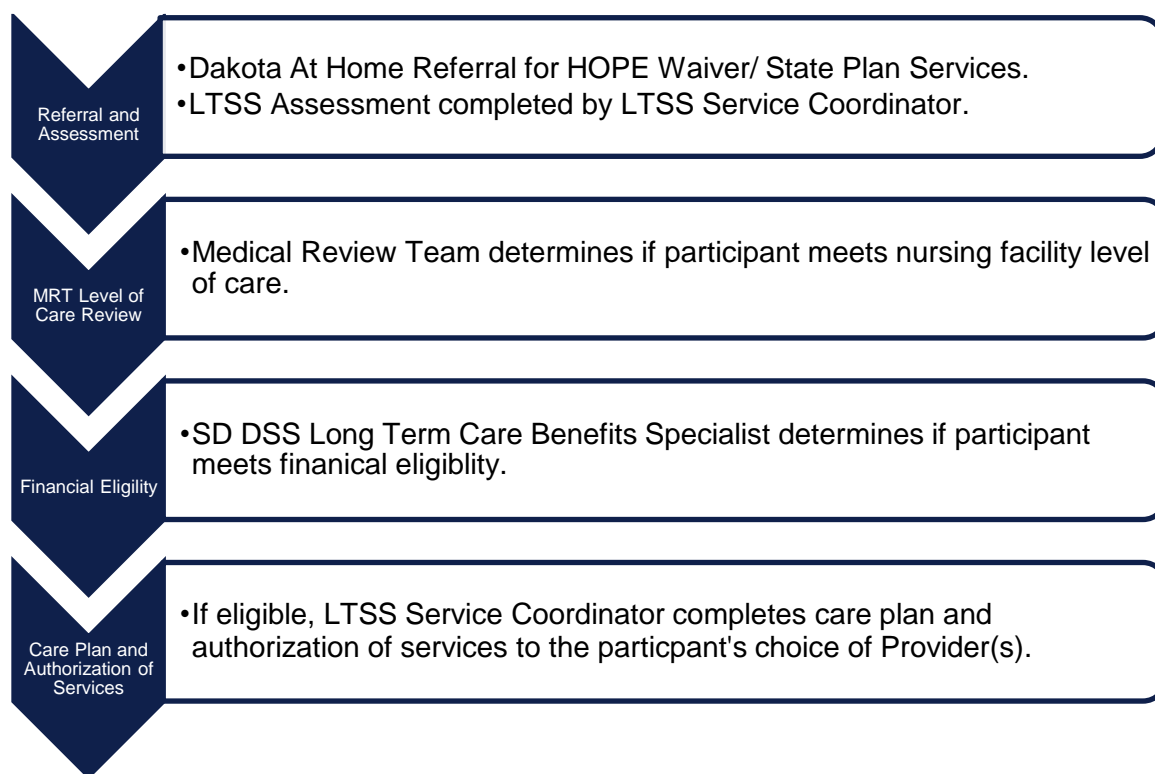
Providers are responsible for checking a participant's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal and Therap.

If the Provider wishes to determine if an individual not eligible for Medicaid and/or not authorized in Therap meets the eligibility criteria for assistance, the Provider and/or individual may contact [Dakota at Home](#) or may submit a coverage request via the Medicaid Portal to determine if assistance with payment is available. This must be done prior to the provision of services, as neither a [Dakota at Home](#) referral nor a coverage request ensures payment in full or in part. As a reminder, individuals must be 18 or older to qualify.

In order to be eligible for services provided through the HOPE Waiver, individuals must meet the following criteria as determined by the Division of Long-Term Services and Supports Medical Review Team (MRT):

- Age 65 and older or age 18 or older with a qualifying disability (a disability that results in needs requiring long term supports and services that cannot be met in a less restrictive environment).
- Have a reasonable indication of need for services based on a standardized assessment.
 - It must be anticipated that individual will require at least one HOPE Waiver service (as documented in the Care Plan (678E)) at least once per calendar month.
- Meet Nursing Facility Level of Care as determined by the Medical Review Team.
- Must not be a resident of a Hospital, a Nursing Facility, or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
 - Please note, individuals residing in these settings may be eligible for the Money Follows the Person (MFP) Program. This program assists individuals to transition to a less-restrictive setting. For more information and/or to make a referral to the MFP program please visit the [MFP webpage](#).
- Meet financial eligibility as determined by Department of Social Services Division of Economic Assistance Long Term Care Benefits Specialist (LTC BS).

Eligibility Determination Process Overview



Assessment

The Home Care Assessment (HCA) is the standardized assessment tool that is utilized to determine if an individual meets the functional eligibility/level of care requirement for the HOPE Waiver. An LTSS

Case Management Specialist, a DHS employee that is responsible for the case management of HOPE Waiver participants, completes the Home Care Assessment (HCA) with the HOPE Waiver participant in the home and submits the completed assessment to the Medical Review Team (MRT). The Medical Review Team (MRT) determines if the individual meets the level of care requirement for the HOPE Waiver. If the individual meets the level of care and is otherwise eligible for the HOPE Waiver, the LTSS Case Management Specialist utilizes the HCA to identify the assessed needs of the HOPE Waiver participant. Together, the LTSS Case Management Specialist and the HOPE Waiver participant develop an Individual Support Plan (ISP) to meet the specific needs of the HOPE Waiver participant.

Individual Support Plan (ISP)

HOPE Waiver services must be delivered according to an Individual Support Plan (ISP). The ISP must be finalized prior to HOPE Waiver services being rendered. Services are based on assessed need as identified in the person-centered ISP with a threshold equal to the average cost of nursing facility care. Services over this threshold are subject to an exceptions process. The ISP is developed collaboratively with the HOPE Waiver participant, the LTSS Case Management Specialist and any other individuals (i.e. family, friends, supports) who the HOPE Waiver participant requests to participate.

The Individual Support Plan (ISP) is required to be completed at least annually or as the HOPE Waiver participant's needs change. The LTSS Case Management Specialist will contact the HOPE Waiver participant two weeks after the start of services to make sure the services are being provided and are meeting the HOPE Waiver participant's needs. The LTSS Case Management Specialist is responsible for the case management of the HOPE Waiver participants. LTSS staff schedule quarterly telephone contacts with the participant at three months and nine months and an in-home visit at six months.

If a HOPE Waiver participant is between the ages of 18 and 21, all State Plan services must be accessed prior to authorizing HOPE Waiver services. There are State Plan services specific to this age group that are provided through the Medicaid State Plan that must be considered.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the [General Coverage Principles](#) manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- The recipient must be eligible;
- The participant must have an Individual Support Plan (ISP) on file with the Division of Long-Term Services and Supports; and
- The Provider must only bill for services delivered by the provider and authorized and acknowledged in Therap. Services not authorized and acknowledged in Therap prior to the provision of services will be denied.

The manual also includes non-discrimination requirements providers must abide by.

Authorized Services

HOPE Waiver services must be related to assessed needs as outlined in the participant's ISP. HOPE Waiver services must be authorized and acknowledged in Therap. Total units authorized are a maximum allowable amount for the entire duration of the Therap Service Authorization. The scheduled frequency and duration of each service is included in the Therap Service Authorization and must be followed. Reimbursement received for units above and beyond the total units, frequency, and/or duration specified in the Therap Service Authorization will be recouped and the Provider will be responsible to continue to provide services at the scheduled frequency and/or duration as indicated on the Therap Service Authorization.

Services must be provided face-to-face with the participant, unless specifically stated otherwise in the Therap Service Authorization. Services are only allowed to be provided in a home or community setting.

LTSS HOPE Waiver Service Codes and Taxonomy Codes			
Services	Service Codes	Taxonomy Code	EVV-required Service
In-Home: Homemaker	S5130	253Z00000X	Yes
In- Home: Personal Care	T1019	253Z00000X	Yes
In-Home: Nursing	T1000	253Z00000X	Yes
In-Home: Adult Companion	S5135	253Z00000X	Yes
In-Home: Chore	S5120	253Z00000X	Yes
Respite	T1005	385H00000X	Yes
Residential Respite Care	S5150	385H00000X	No
Assisted Living	T2031	310400000X	No
Structured Family Caregiving	T2033	311Z00000X	No
Community Living Home	T2033	311ZA0620X	No
Adult Day	S5100	261QA0600X	No
Community Transition Coordination	T1016	251B00000X	No
Community Transition Supports	T2038	251X00000X	No
Environmental Accessibility Adaptations Assessment	T1028	171WH0202X	No
Environmental Accessibility Adaptations	S5165	171WH0202X	No
Specialized Medical Equipment, Assistive Technology	T2029	332BN1400X	No
Assistive Technology	A9279	332BN1400X	No
Specialized Medical Supplies	T5999	332BN1400X	No
Emergency Response Service	S5161	33330000X	No
Nutritional Supplements	S9977	332BP3500X	No
Meals	S5170	332U00000X	No

Assisted Living Services (T2031)

Assisted Living is a covered service. Assisted Living includes homemaker, personal care, chore, and meal preparation for participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable participant needs and to provide

supervision, safety and security. The Assisted Living location promotes the health, treatment, comfort, safety, and well-being of participants, with easy accessibility for visitors and others.

The concurrent provision of homemaker, personal care, chore services, emergency response systems, respite care, meals and environmental accessibility adaptations as distinct additional services is prohibited for a participant who resides in Assisted Living, as they are an integral part of the Assisted Living service.

Services also include social and recreational programming, and medication assistance (to the extent permitted under State law). Services that are provided by third parties must be coordinated with the Assisted Living provider.

Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living services. Payment is not made for 24-hour skilled care.

Additional services that can be provided, based on assessed need, to participants in Assisted Living include Specialized Medical Equipment, Specialized Medical Supplies, Nutritional Supplements, Adult Day, Nursing and Adult Companion. The additional services must be provided by a third party and may not be provided by the Assisted Living provider.

Room and board, items of comfort or convenience, cost of facility upkeep, maintenance, etc. are not covered. Room and board and items of comfort and convenience are the participant's responsibility. Facility upkeep and maintenance are the responsibility of the facility.

For the Assisted Living Center to be reimbursed the participant must be physically present in the Assisted Living Center and must be receiving the assisted living service, except in the following situations:

- Hospital reserve bed days: An Assisted Living Center may bill Medicaid for a maximum of five consecutive days when a recipient is admitted to an inpatient hospital stay. Up to five consecutive days may be billed to Medicaid per hospitalization; however, the recipient must return to the Assisted Living Center for a minimum of 24 hours before additional hospital reserve bed days will be paid.
- Therapeutic leave days: An Assisted Living Center may bill Medicaid for a maximum of five therapeutic leave days per month. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Assisted Living Center for non-medical reasons (e.g., visits to the homes of family or friends).

Rate Tiers

Assisted Living Centers are reimbursed at three tiers (base, U1, U2) according to the HCA completed by the LTSS Case Management Specialist. The HCA is completed annually with all HOPE Waiver participants. Assisted Living staff are encouraged to participate in the assessment process to ensure the most appropriate tier is assigned. The information collected on the HCA generates a RUG score based on an algorithm developed by InterRAI. The RUG scores are assigned to tiers.

Additional Claims Requirements

A modifier U1 or U2 must be listed on the claim to reflect the appropriate tier if the recipient is Tier U1 or U2. The modifier must be listed in Box 24D.

Adult Day Services (S5100)

Adult Day services are a covered service. Adult Day services provide regular care, supervision and structured activities in a non-institutional community-based setting. Adult Day services include both health and social services needed to ensure the optimal functioning of the participant for a period of less than 24 hours per day. Adult Day services are provided to a participant who lives at home. Nutritious meals are available but are billed as a separate service. Bathing may also be available and be billed as a separate service if authorized. Adult Day services are integrated in the community. Although not required, Nursing services are provided based on assessed need and include health screenings, blood pressure checks, medication management, and a general assessment of the participant's condition.

If a participant residing in an Assisted Living Center prefers that his or her socialization needs be met in an Adult Day environment, Adult Day services may be authorized. When this occurs, Adult Day services must be provided by a HOPE Waiver-approved Adult Day provider (not the Assisted Living). The Assisted Living is required to arrange or provide non-medical transportation to the Adult Day setting. Adult Day services as an additional service for participants residing in an Assisted Living may not be utilized for bathing purposes only. Meals may not be authorized as a separate service when a participant residing in an Assisted Living attends Adult Day services.

Specialized Medical Equipment (T2029)

Specialized medical equipment includes devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living and assist the participant to remain living safely at home. Services consist of purchasing, leasing, installation, or otherwise providing the equipment or appliance to be used to increase, maintain, or improve functional capabilities of participants. Specialized medical equipment reimbursed by the HOPE Waiver is in addition to any medical equipment furnished under the Medicaid State Plan [Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#) benefit and excludes items that are not a direct medical or remedial benefit to the participant.

In order to ensure that medical equipment available through the Medicaid State Plan, DMEPOS benefit is accessed prior to authorizing Specialized Medical Equipment through the HOPE Waiver. The LTSS Case Management Specialist will authorize Specialized Medical Equipment through HOPE Waiver only when the Provider is able to submit a Medicaid remittance advice with the following denial reasons:

- "Services not covered by Medicaid" or "Statutorily excluded service" denial code N425 on electronic remittance advice
- "Service limitation error for this procedure" or "This claim/service must be billed according to the schedule for this plan" denial code N182 on electronic remittance advice.

When Specialized Medical Equipment authorized exceeds the South Dakota Medicaid service limit, the provider must attach the Therap Service Authorization when submitting the claim to South Dakota Medicaid. The claim must include the following language "Attention Claims Supervisor; review

required.” Failure to submit the Therap Service Authorization with the claim will result in only partial payment of the claim.

Assistive Technology (A9279)

Assistive Technology consists of devices, controls, sensors or appliances that are aided by technology to remotely monitor an individual's activities of daily living. This service includes the installation and monitoring, purchasing, leasing or otherwise providing these devices, controls, sensors or appliances to be used to increase, maintain, or improve functional capabilities of participants specified in the plan of care, that enable participants to increase their ability to perform activities of daily living and assist the participant to remain living safely at home.

Specialized Medical Supplies/ Diabetic, Wound Care and Other Supplies (T5999)

Specialized Medical Supplies are disposable supplies which are necessary to maintain a participant's health, manage a medical or physical condition, improve functioning, or enhance independence as specified in the Individual Support Plan (ISP). Medical Supplies reimbursed with HOPE Waiver funds are in addition to any medical supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant.

In order to ensure that Specialized Medical Supplies available through the Medicaid State Plan, DMEPOS benefit is accessed prior to authorizing Specialized Medical Supplies through the HOPE Waiver. The LTSS Case Management Specialist will authorize Specialized Medical Supplies through HOPE Waiver only when the Provider is able to submit a SD Medicaid remittance advice with the following denial reasons:

- “Services not covered by Medicaid” or “Statutorily excluded service” denial code N425 on electronic remittance advice
- "Service limitation error for this procedure" or "This claim/service must be billed according to the schedule for this plan" denial code N182 on electronic remittance advice.

When Specialized Medical Supplies authorized exceeds \$300, the provider must attach the Therap Service Authorization when submitting the claim to South Dakota Medicaid. The claim must include the following language “Attention Claims Supervisor; review required.” Failure to submit the Therap Service Authorization with the claim will result in only partial payment of the claim.

Environmental Accessibility Adaptations (S5165) & Assessment (T1028)

Environmental Accessibility Adaptations (EAA) are physical adaptations to the private residence of the participant, or the participant's family, required by the participant's Individual Support Plan (ISP), that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric or plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant are not covered. Adaptations or improvements that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an

adaptation (i.e., in order to improve entrance/egress to a residence or to widen a bathroom to accommodate a wheelchair). This service does not include general repair or maintenance to the residence, which are considered to be standard housing obligations of the owner or tenant.

The provider is allowed to bill an Initial Assessment for the in-home face-to-face staff time to obtain project specifics and obtain at least two bids and secure a contract for the EAA. In addition, the provider is allowed to bill a Final Assessment for the in-home face-to-face staff time to assess completion of the project for compliance and safety and ensure the project meets the needs of the participant.

When EAA authorized exceed \$5,000.00, the provider must attach the Therap Service Authorization when submitting the claim to South Dakota Medicaid. The claim must include the following language "Attention Claims Supervisor; review required." Failure to submit the Therap Service Authorization with the claim will result in only partial payment of the claim.

Environmental Accessibility Adaptations may not be authorized for a participant residing in an Assisted Living

Meals (\$5170)

Meals are based on an assessed need and authorized when a participant lives in his/her own home. Meals follow federal dietary guidelines and can be provided for breakfast, lunch and dinner to enhance a participant's diet.

Meals may not be authorized for a participant residing in an Assisted Living. Meals are provided by the Assisted Living as part of Room and Board, which is paid directly to the Assisted Living by the participant.

Nutritional Supplements (\$9977)

Nutritional supplements are covered when provided to a participant at home who is below his or her medically recommended body weight or nutritionally deficient or malnourished. It is also covered to promote wound healing or to manage other health conditions. Services must be under the direction of a physician and require a physician's order. Nutritional Supplements may be authorized for a participant residing in an Assisted Living.

Additional Claims Requirements

The referring physician's name must be listed in box 17 and his or her NPI must be listed in box 17b on the Service Authorization in Therap.

Emergency Response Systems (\$5161)

An Emergency Response System is an electronic device that enables a participant who lives in his or her home to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to a participant's phone and programmed to signal a response center once a "help" button is activated. The provider may not bill more than their usual and customary fee for an emergency response system. LTSS does not pay for installation of emergency response systems. An Emergency Response System is not covered for a participant residing in a provider owned residential setting.

Community Transition Services (T2038)

Community Transition Coordination is a service that assists eligible individuals who are transitioning to a less restrictive setting in identifying, selecting, and obtaining both paid and unpaid services as well as integrated community housing options. For eligible individuals living in a nursing facility/institution, community transition coordination is available for up to 180 consecutive days prior to an individual's date of waiver enrollment and transition to the community. The date the person leaves the institutional setting and is enrolled in the waiver is the date of service for billing purposes.

For individuals already enrolled in the HOPE waiver and living in a provider-controlled residential setting, community transition coordination is available for up to 180 consecutive days prior to an individual's move to a more integrated residential setting.

If for an unforeseen reason the person does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transition service that was being provided may be covered through Medicaid administrative funding.

Community transition coordination service limitations include:

- Services must be reasonable and necessary;
- Services must be clearly specified in the person-centered Transition Plan;
- Limited to one time per waiver enrollment;
- Limited to 180 consecutive days prior to transition; and
- Limited to 90 days post transition.

Billable Services

- Providing Information and education on the HOPE waiver service options, including the individual's rights and responsibilities.
- Assessment
 - Preparing for, scheduling, and completing an initial assessment.
 - Preparing for, scheduling, and completing reassessment if changes occur.
- Transition care plan development
 - Preparing for, scheduling, and holding person-centered care plan meeting and documenting the outcome.
 - Preparing evaluating and revising the care plan due to changes and documenting the outcome.
- Assistance to access service providers
 - Completing referrals and related activities to help the participant obtain needed services.
 - Linking eligible participants with medical, social, educational providers or other programs and services that are capable of providing needed services.
- Assistance in identifying and securing integrated community housing
 - Making contacts with landlords and providers in order to locate and secure suitable housing.
 - Making preparations necessary for a successful transition including:
 - Ensuring a lease is signed and a security deposit is made (if needed).

- Ensuring that utilities are connected and in working order (e.g. telephone, electricity, heating and water).
 - Ensuring essential home/apartment furnishings are obtained and in place.
 - Ensuring other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, initial setup for groceries and personal care items.
 - Providing information, education and training for the participant regarding:
 - Household budget, living costs, and lease and utility arrangements.
 - Security features and the safe operation of appliances in the home.
 - Availability and how to access Community resources.
 - Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging finishing, appliances, and other household items.
 - Ongoing monitoring of the transition to ensure it remains successful including:
 - Daily calls for 2 weeks.
 - Face-to-face visits as needed, but at least weekly.
 - Weekly communication with providers of in-home services to ensure service provision.
 - Routine communication with LTSS Case Management Specialist regarding authorized services and necessary updates to Care Plan.
 - Report knowledge of any critical incidents to LTSS.
 - Refer complaints about provider to LTSS Case Management Specialist.
 - Identify factors that may contribute to an unsuccessful community placement and complete activities to prevent readmission to a more restrictive environment such as:
 - Follow-up with landlord at regular intervals to ensure rent is paid.
 - Follow-up with utility companies to ensure bills are being paid.
 - Follow-up counselors to ensure appropriate services are being accessed.
 - Assist in completion of applications and recertification of public assistance programs such as SNAP, LIEAP.
- Arrange appointments with mental health and other professionals and follow up to ensure appointments are attended.

Community Transition Supports (T1016)

Community transition supports are non-recurring, one-time expenses to provide essential household items and/or services to eligible individuals.

For eligible individuals living in a nursing facility/institution, community transition supports are available for up to 180 consecutive days prior to an individual's date of waiver enrollment and transition to the community. The date the person leaves the institutional setting and is enrolled in the waiver is the date of service for billing purposes.

If determined necessary for a successful transition, the following waiver services are available to individuals transitioning from an institutional setting for up to 60 consecutive days prior to the transition date:

- Environmental Accessibility Adaptations (prohibited if individual transitions to a setting in which another party is responsible for such adaptations); and
- Specialized Medical Equipment.

For individuals already enrolled in the HOPE waiver and living in a provider-controlled residential setting, community transition supports are available for up to 180 consecutive days prior to an individual's move to a more integrated residential setting. If determined necessary for a successful transition, all waiver services are available unless otherwise prohibited by individual service limitations.

Community transition supports enable an individual to establish a basic household and may include any or all the following expenses:

- A security deposit required to obtain a rental lease for an apartment or house;
- Moving expenses required to occupy and use the residence;
- One-time non-refundable deposits or installation fees to establish utility and other essential service access, e.g., telephone, electricity, heating and water;
- One-time residential cleaning or pest extermination costs required for the individual to occupy the residence;
- Non-medical transportation necessary to the transition;
- Furniture; and
- Essential household items necessary for a successful diversion as determined by a needs assessment including:
 - Small appliances;
 - One time/initial set up for groceries;
 - Household supplies (e.g. hand soap, detergent, toilet paper, paper towels, cleaning supplies); and
 - Bathroom, kitchen, and bedroom linens (e.g. hand towels, bath towels, dishrags, and bed sets.

The Community Transition Specialist will accompany the participant to purchase essential household items. The total cost of the essential household items is limited to \$500.

Service Limits

Community transition supports must meet the following limits:

- Must be reasonable and necessary;
- Must be clearly specified in the person-centered Transition Plan;
- Limited to one time per waiver enrollment;
- Limited to goods and services not available to individuals through other means;
 - Not available to individuals accessing transition services through the Money Follows the Person Demonstration Grant;
 - Not available to pay for furnished living arrangements that are owned or leased by a waiver provider where the essential household items and services are already included in the provider's provision of service; and

- Not available to pay for furnished living arrangements that are the responsibility of a third party (e.g. landlord).
- Limited to goods and services purchased within 60 days of the date of transition;
- The total cost of all items/services purchased is limited to \$5,000;
 - When the total cost to maintain a participant's health and safety needs upon transition exceed \$5,000, any additional costs must be approved through an exceptions process.
- Community transition supports do not include the following expenses:
 - Household items (water heater, furnace/heater, furnished furniture, air conditioner) that are the responsibility of the landlord or property owner to provide, replace, repair;
 - Payment for room and board;
 - Monthly rent or mortgage expense;
 - Food (with the exception of one-time/initial set up of groceries);
 - Regular or ongoing utility fees/charges; and
 - Items intended for diversion/recreational purposes, i.e., televisions, cable TV access, DVD/Blue-ray players, streaming services.
- Limited to 180 consecutive days prior to transition; and
- Limited to 90 days post transition.

If for an unforeseen reason the person does not enroll in the waiver (e.g., due to death, significant change in condition, etc.), the transition service that was being provided may be covered through administrative funding.

Structured Family Caregiving (T2033)

The Structured Family Caregiving (SFC) service offers HOPE Waiver participants an opportunity to reside with a principal caregiver in their own private home or in the private home of the principal caregiver. The HOPE Waiver participant receives assistance with daily personal care and other needs from the principal caregiver while the principal caregiver receives education, ongoing coaching, and a financial stipend from a SFC provider agency.

The SFC principal caregiver may be a related family member or non-relative fictive kin. Non-relative fictive kin is defined as an individual who is not related by birth, adoption, or marriage but who has an emotionally significant relationship with the participant. If the SFC principal caregiver is not a related family member or fictive kin, the home must also be licensed by the South Dakota Department of Health as a Community Living Home as defined in [ARSD Ch. 44:82](#).

Hospital Days

A Structured Family Caregiver oversight agency may bill Medicaid for reserve bed days for a maximum of five consecutive days when a participant is admitted to an inpatient hospital stay. Up to five consecutive days may be billed per hospitalization; however, the participant must return to the SFC Home for a minimum of 24 hours before additional hospital reserve bed days will be paid.

Rate Tiers

SFC has three rate tiers (base, U1, U2) which are based on the level of support a participant requires. The participant's tier is established by the LTSS Case Management Specialist based on information collected through the intake and assessment process (Rug-III/HC Group Number). When an SFC Provider Agency

notes a significant change in the participant's status and daily care needs, the provider may request a reassessment by the LTSS Case Management Specialist. The rates are the daily payment to the SFC Provider Agency and include the payment to the provider and the stipend that is paid to the caregiver. SFC Provider Agencies individually establish the caregiver stipend amount. Caregiver stipends must equal at least 50 percent of the established rate tier. Questions about the caregiver stipend should be forwarded to the SFC Provider Agency. Current rates for SFC can be found at <http://dhs.sd.gov/ltss/ltssproviders.aspx>.

Service Limits

Meals, homemaker services and/or chore services are not separately covered or reimbursable for participants receiving SFC services as these activities are integral to and inherent in the provision of SFC. Payments made for SFC are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement.

Additional Claims Requirements

The provider must list modifier U1 or U2 to reflect the appropriate tier if the participant is Tier U1 or U2. The modifier must be listed in box 24D. Hospital days must be billed with a place of service code 21 in box 24B on a CMS 1500 claim form.

Community Living Home (T2033)

Community Living Home residential services offer waiver participants an opportunity to receive supports and services in a licensed home. The purpose of this service is to provide necessary care and supervision for the participant, and to provide opportunity for the participant to remain in the community in the most integrated setting. Participant needs shall be addressed in a manner that support and enable the individual to maximize abilities to function at the highest level of independence possible. The service is designed to provide an alternative long-term care option to persons who meet Nursing Facility level of care and whose needs can be met in a Community Living Home setting.

The Community Living Home residence may be owned, leased or rented by the provider and must be licensed by the South Dakota Department of Health, consistent with [ARSD Ch. 44:82](#). The Community Living Home provider must ensure the basic health and safety needs of the waiver participant are met 24 hours per day, 7 days per week. The maximum number of participants receiving Community Living Home services in any one residence may not exceed four people.

Separate payment for meals, homemaker services, chore services, respite care, personal emergency response services, or environmental accessibility adaptations, will not be provided on behalf of participants receiving Community Living Home services as these activities are integral to and inherent in the provision of Community Living Home services. Payments made for Community Living Home services are not made for room and board, items of comfort or convenience, or the costs of home maintenance, upkeep and improvement.

For a provider to be reimbursed at the established rate the participant must be physically present in the Community Living Home and must be receiving the community living home service except in the following situations:

Hospital reserve bed days: A Community Living Home may bill Medicaid for a maximum of five consecutive reserve bed days when a recipient is admitted to an inpatient hospital stay. Up to

five consecutive days may be billed per hospitalization; however, the recipient must return to the Community Living Home for a minimum of 24 hours before additional hospital reserve bed days will be paid. When a participant is transferred from a Community Living Home to a hospital, it is expected that the Provider will accept the participant back at the Community Living Home at the time of hospital discharge.

Therapeutic leave days: A Community Living Home may bill Medicaid for a maximum of five therapeutic leave days per month per participant. Therapeutic leave days may be consecutive or non-consecutive. Therapeutic leave days are leave days from the Community Living Home for non-medical reasons (e.g., visits to the homes of family or friends).

Rate Tiers

Community Living Home services are reimbursed at three tiers (base, U1, U2) according to the HCA completed by the LTSS Case Management Specialist. The HCA is completed annually with all HOPE Waiver participants. Community Living Home staff are encouraged to participate in the assessment process to ensure the most appropriate Tier is assigned. The information collected on the HCA generates a RUG score based on an algorithm. The RUGS scores are assigned to tiers.

Additional Claims Requirements

The provider must list modifier U1 or U2 to reflect the appropriate tier if the participant is Tier U1 or U2. The modifier must be listed in box 24D.

Chore Services (S5120)

Chore services needed to maintain the participant's home in a healthy and safe environment are covered. Chore services are limited to lawn mowing, snow and ice removal from sidewalks and driveways, or other services which the homeowner is required to complete by city or county ordinance.

The HOPE Waiver is the payer of last resort for Chore services. Community resources and other informal supports that are available must be utilized prior to HOPE Waiver services. Providers are not required to document the applicable city ordinance for snow shoveling and lawn mowing. Other Chore services required by city ordinance must include documentation or notification of the requirement.

Homemaker Services (S5130)

Homemaker services consist of the performance of general household tasks provided by a homemaker, when the participant is unable to manage the home and care for him or herself. Homemaker services are included within personal care services in South Dakota's Medicaid State Plan.

Homemaker services within this HOPE Waiver are those services that are provided when Homemaker personal care services furnished under the approved State Plan limits are exhausted. The scope and nature of these services do not differ from Homemaker services furnished under the State Plan. The provider qualifications specified in the State Plan apply. The services that may be provided through the HOPE Waiver are in addition to the 500 hours allowed in the State Plan.

Homemaker services are included in the scope of services provided to a participant living in Assisted Living. Homemaker services may not be authorized for a participant residing in an Assisted Living.

Personal Care (T1019)

Personal Care includes assistance provided to a participant living at home to perform his or her activities of daily living. In-Home Personal Care services are those services provided when 500 hours of personal care furnished under the approved State Plan limits are exhausted. The additional number of services that may be provided through the HOPE Waiver is the provision of additional Personal Care services over 500 hours. The provider qualifications specified in the [Personal Care Agency Services](#) provider manual apply.

Personal Care services are included in the scope of services provided to a participant living in Assisted Living. Personal Care services may not be authorized for a participant residing in an Assisted Living.

Residential Respite Care (S5150)

Residential Respite Care will provide short-term (less than 30 consecutive days) for an individual who is unable to care for him or herself in the absence of or for the relief of the caregiver. Residential Respite Care is available to eligible individuals who reside within an assisted living center. Residential respite care is not covered in an adult day setting.

Adult companion Services (S5135)

Adult Companion services are non-medical care, assistance, supervision or socialization provided to a participant living at home or in Assisted Living. Companions perform tasks that are incidental to the care and supervision of the participant as opposed to completing the tasks for the participant. Completion of Homemaker, Personal Care and Chore services will be authorized and provided as distinct, unduplicated services as assessed and specified in the Individual Support Plan (ISP).

In-Home Nursing (T1000)

In-Home Nursing includes care provided by a licensed nurse within the scope of State of South Dakota Codified Law. In-Home Nursing services are provided under the HOPE Waiver when nursing services furnished under the Personal Care nursing State Plan 500-hour limit is exhausted. The scope and nature of these services do not differ from nursing services furnished under the State Plan as described in the [Personal Care Agency Services](#) provider manual. The provider qualifications specified in the State Plan apply.

Nursing services may be authorized for a participant residing in an assisted living. Nursing services in an assisted living are intended to be used only for situations in which nursing services for a participant residing in an assisted living are temporarily anticipated to go above and beyond what the assisted living is able to provide in order to avoid nursing facility placement. When nursing in an assisted living is requested, the Case Management Specialist must gather information regarding the situation and forward to the HCBS Manager for review and approval. The additional nursing services must be provided by a Medicare Certified Home Health Agency. Not all HOPE Waiver providers are Medicare Certified Home Health Agencies. The services must not take the place of the nursing services already being provided through the assisted living and may not be authorized when the participant is eligible for Medicare.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the [Documentation and Record Keeping](#) manual for additional requirements.

Electronic Visit Verification Requirements

In addition to the requirements listed in the Documentation and Record Keeping manual, the following services are subject to EVV requirements:

- Adult Companion (S5135)
- Chore (S5120)
- Homemaker (S5130)
- In-Home Nursing (T1000)
- Personal Care (T1019)
- Respite (T1005)

Providers of these services must comply with federal EVV requirements and collect EVV data at the time services are rendered. The State has purchased an EVV system for providers to utilize at no cost to the provider. If the provider determines utilization of the State purchased EVV system is not feasible, the provider may complete the [Provider Request for Approval for Alternative IT System for Electronic Visit Verification \(EVV\)](#) form. If an alternative IT system is approved, the provider must ensure the minimum EVV requirements are met. EVV requirements include the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends.

Additional Claims Requirements for EVV services include:

- 1) Prior authorization number identified on the Therap Service Authorization.
- 2) For In-Home Nursing services only, list the referring Physician's Name (box 17) and NPI (box 17b) identified on the Service Authorization in Therap.

REIMBURSEMENT AND CLAIM INSTRUCTIONS

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are

received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information. the Provider Manuals [webpage](#).

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Third-Party Liability billing instructions when applicable. Providers should refer to the [General Claim Guidance](#) manual for additional information.

Reimbursement

HOPE Waiver agencies must bill for services at the provider's usual and customary rate. Covered services will be reimbursed at the lesser of the provider's usual and customary rate or the rate on the Community Health Worker [fee schedule](#) .

Hospice Services

Participants may receive both HOPE Waiver services and hospice services if the HOPE Waiver services were in place prior to the hospice services being elected and are unrelated to the terminal illness that resulted in the election of hospice care. It may be appropriate for HOPE Waiver services to be started after a participant has elected hospice services if the HOPE Waiver services are unrelated to the terminal illness that resulted in the election of hospice care. HOPE Waiver services may not be utilized as a means by hospice providers to forgo providing core and supplemental services that they are required to provide.

When billing for HOPE Waiver services for a participant that has elected hospice care, the provider must attach the Therap Service Authorization when submitting the claim to South Dakota Medicaid. The claim must include the following language "Attention Claims Supervisor: Review Required".

Care Plan Cost Share

The cost share for HOPE Waiver services is a component of the financial application for HOPE Waiver and is determined by the Department of Social Services (DSS), Division of Economic Assistance (EA). Both the maximum gross income for HOPE Waiver eligibility and the standard needs allowance (the amount a HOPE Waiver participant is allowed to keep for daily living expenses) is 300% of the SSI standard for the year. The HOPE Waiver participant will be notified of his/her cost share via a notice from DSS/EA.

The cost share will be deducted from the providers' payment from South Dakota Medicaid. The cost share will be deducted from claims in the order they are received and processed by South Dakota Medicaid. If a cost share is applied, the provider is responsible for collecting the copayment amount from the HOPE Waiver participant. For Assisted Livings and Community Living Home services, providers will receive notification of the participant's cost share from the DSS Long Term Care Benefits Specialist. For all other HOPE Waiver services, the provider will be notified by LTSS' HCBS Provider Operations Manager via e-mail as the cost share is applied. The cost share will not exceed the cost of services the HOPE Waiver participant is receiving.

Claim Instructions

HOPE Waiver services must be billed on a CMS 1500 claim form or via an 837P electronic transaction. Detailed claim form instructions are available on the Provider Manuals [webpage](#). All LTSS providers have the capability to bill for all HOPE Waiver claims through the LTSS case management and billing system, Therap.

Services reimbursed in 15-minute units, are only billable if at least 8 minutes of service were provided. Providers must use the following table to determine the number of units that should be billed.

Unit	Time
1 Unit	8-22 minutes
2 Units	23-37 minutes
3 Units	38-52 minutes
4 Units	53-67 minutes

With the exception of community transition services and supports, which must be billed with a date that is on or after the date of the transition to the community, it is a fraudulent billing practice to list a date of service on the claim other than the date the service was rendered. A provider engaged in this practice may be subject to recoupment of payment, termination of the provider agreement and referral to the Medicaid Fraud Control Unit in the Attorney General's Office. Services may be billed on a monthly basis, but documentation must be for each date of service.

HOPE Waiver Claim Denials

For assistance with claim denials, the provider must notify the State within 6-month time limits outlined in [ARSD 67:16:35:04](#). For all HOPE Waiver claim inquiries directed to LTSS, providers must submit a Claim Resolution Template to ltsstherap@state.sd.us for further review. Providers are encouraged to resubmit all previously denied claims every 90 days for South Dakota Medicaid and DHS/LTSS claims compliance. The Claims Resolution Template is located on the DHS/LTSS Provider Resources page at <https://dhs.sd.gov/ltss/ltssproviders.aspx>.

DEFINITIONS

1. "Electronic Visit Verification 'EVV,'" means with respect to personal care services or home health services, a system which visits conducted as part of such services are electronically verified with respect to the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the service and the time the service begins and ends;
2. "Individual Support Plan (ISP)," an electronic document within each participant's record in the Therap case management system and whomever he/she wishes to participate. The ISP summarizes the participant's identified needs and the strategy for addressing unmet needs. All participants have the opportunity to identify whomever he/she wishes to participate in their ISP;
3. "Therap," the online case management documenting and billing software supported by DHS/LTSS;

4. "Therap Service Authorization," the electronic document in Therap which details the services authorized for the participant; and
5. "Qualifying Disability," is a participant that qualifies for Supplemental Security Income (SSI), Social Security Disability Income (SSDI), or is determined disabled by the Disability/Incapacity Consultation Team (DICT).

REFERENCES

- [Administrative Rule of South Dakota \(ARSD\)](#)
- [Code of Federal Regulations](#)
- [LTSS Provider Resources](#)

QUICK ANSWERS

1. How would a provider get LTSS assistance with HOPE Waiver claim denials?

For assistance with claim denials, the provider must notify the State within 6-month time limits outlined in [ARSD 67:16:35:04](#). For all HOPE Waiver claim inquiries providers must submit a Claim Resolution Template to ltsstherap@state.sd.us for further review. Providers are encouraged to resubmit all previously denied claims every 90 days for South Dakota Medicaid and DHS/LTSS claims compliance. The Claims Resolution Template is located on the DHS/LTSS Provider Resources page at <https://dhs.sd.gov/ltss/ltssproviders.aspx>.

2. Can providers bill for reimbursement for mileage?

Additional units for mileage will not be authorized and must not be billed. Travel time is included in the non-billable time reported in the cost reports and is used to calculate the rate(s) for services.

3. Can providers bill for interpreter/translation services?

If interpreter services are necessary, the provider must utilize DHS-approved Interpreters whenever HOPE Waiver services are authorized by the State. Interpreter services must be approved prior to Interpreter services being utilized. LTSS and the provider will cooperatively arrange for interpreter services as necessary throughout the authorized service period.

4. Who collects the Room and Board portion of payment from participants?

The provider must collect the Room and Board portion of the payment from the participant. Room and Board is only applicable for Assisted Living and Community Living Home HOPE Waiver Services.